Community Infection Prevention and Control Guidance for Health and Social Care

Clostridium difficile

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Organisation: ........................................................................................................

Signed: ...........................................................................................................

Job Title: .........................................................................................................

Date Adopted: ..............................................................................................

Review Date: ..............................................................................................

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CLOSTRIDIUM DIFFICILE

1. Introduction

*Clostridium difficile* (C. difficile) is a bacterium which produces spores which are resistant to air, drying and heat. The spores survive in the environment and are the main route of transmission of the bacterium.

C. difficile produces two major toxins (A and B) that are linked to its pathogenicity (ability to cause disease). The presence or absence of these toxins is detected in the Laboratory as part of the C. difficile testing process.

C. difficile is present harmlessly in the gut (bowel) of 3% of healthy adults as part of their normal gut flora. However, when antibiotics disturb the balance of bacteria in the gut, C. difficile can multiply rapidly producing toxins causing diarrhoea or colitis.

Elderly people with other underlying diseases who have been treated with broad spectrum antibiotics are at greatest risk of C. difficile infection.

The 027 strain of this organism is particularly virulent causing severe morbidity and mortality.

C. difficile has been associated with outbreaks in health and social care settings. It is, therefore, imperative that good infection prevention and control measures are instigated so that transmission does not occur in any health or social care setting.

2. Routes of transmission

There are four main routes of transmission of C. difficile spores:

- transmission via hands, particularly the hands of staff, but also on service users’ hands
- contact with affected service users
- contact with contaminated surfaces or equipment, e.g., commodes, bed pans, furniture
- by direct inoculation into the bowel via contaminated equipment, e.g., sigmoidoscopes, rectal thermometers.

3. Signs and symptoms

If a service user has diarrhoea (types 5-7 on the Bristol Stool Form Scale, see
Appendix 1), that is not attributable to underlying causes, e.g., inflammatory colitis, overflow, or therapy, e.g., laxatives, enteral feeding, then it is necessary to determine if this is due to *Clostridium difficile* infection (CDI).

Symptoms are typically explosive, foul-smelling watery diarrhoea, which may contain blood and or mucus. Some service users pass mucus alone.

CDI produces toxins which cause fluid loss from the gut and cell damage, causing abdominal pain and fever. Dehydration, which can be severe, is common due to fluid loss.

In the majority of service users, the illness is mild and a full recovery is usual. Elderly service users often with underlying illnesses may, however, become seriously ill. Occasionally, service users may develop a severe form of the infection called pseudomembranous colitis which can cause significant damage to the large bowel. This may lead to a grossly dilated bowel, possibly resulting in rupture or perforation leading to peritonitis and death.

4. Risk factors for *C. difficile* infection

The risk factors associated with acquiring CDI are:

- **age** – incidence is much higher in service users aged over 65 years
- **underlying disease** – service users with chronic renal disease, underlying gastrointestinal conditions, and oncology service users
- **antibiotic therapy** – service users who have recently received or who are receiving antibiotic therapy, especially broad-spectrum antibiotics such as cephalosporins, e.g., cefuroxime, quinolones, e.g., ciprofloxacin, co-amoxiclav or clindamycin. CDI has been associated with oral, intramuscular and intravenous routes of administration of antibiotics
- **recent hospital stay** – service users who are frequently in hospital or who have had a lengthy stay in hospital
- **other medication** – service users receiving anti-ulcer medications including antacids and proton pump inhibitors, e.g., omeprazole
- **nasogastric tubes** – service users undergoing treatments requiring nasogastric tubes
- **service users colonised with *C. difficile***.

5. Prevention of *C. difficile* infection

The main methods of prevention are:

- prudent antibiotic prescribing:
Clostridium Difficile

Antibiotics should not be prescribed unless necessary
- where possible broad spectrum agents should be substituted by those with a narrower spectrum of activity
- courses should be as short as the clinical condition allows
- use of antibiotics associated with CDI should be avoided where possible
- your local Antibiotic Prescribing Policy should be followed where possible.

Preventing transmission from service user to service user:
- prompt isolation of any service user with diarrhoea (stool types 5-7, see Bristol Stool Form Scale, Appendix 1) in a health or social care setting. Isolate as soon as symptoms become apparent; do not wait for microbiology results
- send a stool sample for C. difficile testing promptly
- good hand hygiene practices by health and social care staff, service users and visitors – hand washing with liquid soap and warm water (not alcohol handrub) when caring for service users with diarrhoea of unknown origin or with C. difficile. Alcohol handrub should not be used as it is not effective at killing C. difficile
- use of appropriate personal protective equipment
- encouraging a high standard of service user hand hygiene by offering hand wipes to those service users unable to wash their hands
- reducing the number of spores in the environment by maintaining scrupulous cleaning of the health or social care setting environment, furniture and equipment.

Health and social care workers should apply the following mnemonic protocol (SIGHT) when managing suspected potentially infectious diarrhoea.

**Table 1: SIGHT mnemonic (adapted from Clostridium difficile infection: How to deal with the problem)**

<table>
<thead>
<tr>
<th>S</th>
<th>Suspect that a case may be infective where there is no clear alternative cause for diarrhoea</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Isolate the service user if in a health or social care setting</td>
</tr>
<tr>
<td>G</td>
<td>Gloves and aprons must be used for all individual contacts with the service user and their environment</td>
</tr>
<tr>
<td>H</td>
<td>Hand washing with liquid soap and warm water should be carried out before and after each contact with the service user’s environment</td>
</tr>
<tr>
<td>T</td>
<td>Test the stool for toxin by sending a specimen immediately</td>
</tr>
</tbody>
</table>
C. difficile infection (CDI)
CDI occurs when the bacterium and its toxins are present in the stool and the service user is symptomatic. This is almost always associated with, and triggered by, the prior use of antibiotics prescribed as treatment or prophylaxis. C. difficile affects predominantly the colon and may result in a wide spectrum of disease, ranging from slight diarrhoea to life-threatening pseudomembranous colitis, toxic megacolon and even perforation of the bowel.

C. difficile colonisation
Some people may acquire the bacterium, but remain asymptomatic as the bacterium may not secrete toxin. These are known as C. difficile colonised.

Although treatment is not required for colonisation, health and social care workers need to remain aware that these service users are at high risk of progressing from colonisation to infection. Colonised service users who develop diarrhoea, whether caused by onset of CDI or due to an unrelated cause, present an infection control hazard as they may excrete infectious spores into the environment.

Some strains of C. difficile lack the genes to produce toxin. Service user's colonised with such strains pose no particular infection control hazard. The Laboratory can test samples by polymerase chain reaction (PCR) for the presence or absence of these genes.

Healthy new-borns are frequently colonised with C. difficile during the first two weeks of life.

Colonisation occurs in up to 20% of chronically ill elderly service users.

Hypertoxigenic strains, e.g., 027
Since 2008, CDI case numbers have been falling nationally. However, the proportion of CDI in England caused by the 027 strain has increased substantially in the last few years. This strain is a toxin hyperproducer (hypertoxigenic strain), and has been associated with outbreaks where greater morbidity and mortality have been reported, together with high incident rates in the elderly and unusual number of cases in younger people.

6. Management and treatment
The service user and any existing medications, including aperients, should be reviewed by their GP promptly.

- Inciting antibiotics should be stopped if possible as should other drugs that might cause diarrhoea, see Appendix 2. If it is not appropriate to discontinue antibiotics, it may be possible to substitute agent(s) with a narrower spectrum.
- Anti-peristaltic agents should not be prescribed in acute infection.
• Consideration should be given to stopping/reviewing the need for PPIs in service users with or at high risk of CDI.

• Supportive care should be given to CDI cases, including attention to hydration, electrolyte balance and nutrition.

It is recommended in line with National Guidance that a daily assessment of the severity of CDI (see Appendix 3 – Daily Assessment of C. difficile infection record) should be undertaken.

Service users should be monitored daily for frequency and severity of diarrhoea using the Bristol Stool Form Scale (see Appendix 1). This should be recorded on a Stool Chart (see Appendix 4 – Stool chart for a C. difficile positive service user).

• Service users who are symptomatic with CDI should be prescribed in line with your local Antibiotic Prescribing Policy.

• In mild cases of CDI, and those where the diarrhoea is settling, specific treatment may not be indicated.

• In cases of C. difficile colonisation, specific C. difficile treatment is not usually indicated, although some service users who are symptomatic may require treatment. Advice should be sought from a Consultant Microbiologist.

• Asymptomatic service users do not require treatment, but they should be advised to report any change in bowel habit or the presence of blood or mucus.

• If metronidazole is contraindicated please, discuss treatment with your Consultant Microbiologist.

• If a service user is unable to swallow metronidazole tablets, consider syrup.

• The course of treatment can be repeated if symptoms persist. When in doubt about treatment, discuss with your Consultant Microbiologist.

• If diarrhoea persists after 20 days treatment but the service user is stable, the number of type 5-7 motions has decreased, the WCC is normal and there is no abdominal pain or distension - in such cases, the diarrhoea may be due to post-infective irritable bowel syndrome and the service user may be treated with an anti-motility agent such as loperamide 2 mg prn (instead of the antibiotic treatment). The service user should be closely monitored for evidence of a therapeutic response and to ensure there is no evidence of colonic dilatation.

• Fluid loss may be considerable and, therefore, needs to be monitored closely.

Recurrence of diarrhoea following treatment
Recurrence of CDI occurs in up to 20% of cases after the first episode. This increases to 50-60% after a second episode.
Studies have suggested that some of these relapses are in fact re-infections due to the service user re-infecting themselves from spores in their environment. If a service user relapses, a second course of treatment is usually indicated. See your local Antibiotic Prescribing Policy for further advice or consult with your Consultant Microbiologist.

7. Isolation of service users

For service users in their own home:
- isolation is not necessary for service users with CDI who are in their own home.

In health and social care settings:
- early isolation in health and social care settings helps to both control outbreaks and reduce endemic levels of CDI. An isolation need risk assessment must take place and be documented in the service user's notes
- any service user with confirmed CDI sharing a bedroom in a care facility must be transferred to a single room, ideally with an en-suite facility as soon as possible after diagnosis or onset of symptoms and no later than the end of the day of diagnosis/symptoms. The room they have moved from must be cleaned and disinfected thoroughly
- if the room does not have its own toilet, then a designated commode must be provided and not be used for any other service user
- the procedure for isolation should be clearly explained to service users and visitors
- a notice should be placed on the outer door of the isolation room advising all visitors to contact nursing/care staff before entering
- the door should be kept closed where possible at all times except for entry and exit
- fans must not be used as they can re-circulate the spores in the environment
- when a service user has been diarrhoea free for 48 hours and has passed a formed stool (type 1-4 on the Bristol Stool Form Scale - see Appendix 1), they are no longer infectious and isolation precautions are no longer required. A negative stool sample is not required
- service users who develop diarrhoea following a period of being symptom free, may have been re-infected or relapsed. These service users must be isolated immediately and a stool sample sent for C. difficile testing if more than 28 days since the previous toxin positive result
- a care pathway should be commenced (see Appendix 5).

Please refer to Isolation Guidance for further information.
8. Investigation of C. difficile infection cases

A root cause analysis (RCA) should be conducted by your local infection prevention and control team for each CDI case to identify any lapses in care. By implementing the lessons learned from the RCA, service user safety can be continuously improved.

An in-depth investigation will be undertaken by your local Public Health England Team, involving your Community Infection Prevention and Control Team in the event of:

- **a period of increased incidence (PII) of CDI**: two or more new cases (not relapses) in a 28-day period in a health or social care setting; or
- **an outbreak of CDI**: two or more cases caused by the same strain related in time and place over a defined period that is based on the date of onset of the first case.

Care homes should, therefore, maintain a log of cases by date and location, to aid recognition of an outbreak and the subsequent investigation.

9. Infection prevention and control measures

To reduce the risk of transmission of C. difficile, when a case has been confirmed, movement of staff between the unit where the affected service user is and other units should be kept to a minimum.

**HAND HYGIENE**

- Alcohol handrubs do not kill spores, therefore, should **not** be used.
- Hands should be washed with liquid soap and warm water after contact with each service user/service user’s environment including immediately prior to leaving the isolation room.
- Service users and their visitors should be supplied with information on hand hygiene.
- Service users should be encouraged to wash their hands with liquid soap and warm water, particularly after using the toilet/commode and before eating/drinking. Use of bar soap should be discouraged as it can harbour C. difficile spores.
- Service users unable to access hand washing facilities should be provided with soap based (not alcohol) hand wipes to clean their hands. Assistance should be given to those service users unable to perform hand hygiene themselves; staff should ensure all surfaces of the service user’s hands are wiped sufficiently.
• Visitors should wash hands on entering the isolation room and also to wash their hands with liquid soap and warm water immediately before leaving the isolation room.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
• All health and social care workers (including housekeeping) should wear single use disposable gloves and aprons for all contact with service users and their immediate environment.

• In a care home setting, all visitors (including family and friends) should wear personal protective equipment for all contact with the service user and the service user’s environment. In some circumstances, e.g., end of life, it may be appropriate to allow some relaxation on the wearing of PPE for visitors, but strict hand washing must still be performed.

• Gloves and aprons should be removed (gloves first then apron) after each use/procedure and disposed of as infectious waste. Hands should be washed after removal of personal protective equipment.

• To avoid the risk of contamination, clean supplies of personal protective equipment should not be stored in an isolation area, sluice or in dispensers near contaminated waste or laundry.

CLEANING AND DISINFECTION
C. difficile spores can survive in the environment for months or years if not adequately cleaned. Therefore, an enhanced cleaning schedule should be undertaken.

Cleaning with warm water and a neutral detergent/detergent wipes alone is insufficient to destroy C. difficile spores. Following cleaning, surfaces must be disinfected with a sporicidal product, e.g., 1,000 parts per million (ppm) chlorine-based solution, e.g., Milton dilution of 50 ml in 1 litre of water. A fresh solution must be made up to the correct concentration every 24 hours and the solution bottle must be labelled with the date and time of mixing.

Please note:
• chlorine-based products will bleach fabrics, so should not be used on soft furnishings, upholstery or carpets, clean with detergent and warm water using disposable cloths

• Milton Antibacterial Surface Spray is not effective against C. difficile spores.

Any equipment required for service user management/care should ideally be disposable or must be dedicated for that service user only. Re-usable equipment must be cleaned and disinfected between use on the service user and again when the infectious period is over.

For service users in their own home:
• surfaces in toilets and bathrooms (or where a commode is used) should be cleaned with detergent then disinfected using a 1,000 parts per million (ppm) chlorine-based disinfectant solution, e.g., Milton dilution of 50 ml in 1 litre of water or household bleach made to 1,000 ppm as per manufacturer’s
instructions, ideally after each loose bowel movement, but at a minimum daily, until the service user has been free from diarrhoea for 48 hours and a formed stool (type 1-4 on the Bristol Stool Form Scale, see Appendix 1) has been passed.

In health and social care settings:

- the isolated service user’s en-suite toilet/commode should be cleaned then disinfected after each use using a 1,000 ppm chlorine-based disinfectant solution, e.g. Milton dilution of 50 ml in 1 litre of water. Staff must ensure that all commode or toilet surfaces (including underneath) are cleaned thoroughly. The room where the service user is isolated must be cleaned and disinfected at least on a daily basis
- to facilitate cleaning during the isolation period, the service user’s personal items should be kept to a minimum. All unnecessary items as well as unwrapped food and sweets should be removed from the isolation room
- when the service user no longer requires isolation, the room should undergo a terminal clean with detergent then a chlorine-based disinfectant (see Isolation Guidance for further information on terminal cleans). Soft furnishings, e.g., curtains (bed/window), should be changed and curtain tracks disinfected. Where possible, surfaces and equipment should be steam cleaned. Please refer to Isolation Guidance for more detailed information
- appropriate colour coded cleaning equipment should be allocated for use only in the isolation room and should be removed from the room after each period of cleaning
- mops should be disposable or laundered after each period of cleaning
- buckets should be washed thoroughly with warm water and detergent and wiped with a chlorine-based disinfectant, dried with paper towels or inverted and allowed to air dry
- any concerns regarding the standard of environmental cleanliness must be reported to the person in charge immediately.

10. Laundry

Kylie (re-usable) incontinence pads should not be used, disposable incontinence pads/sheets should be used.

- All health and social care workers should wear disposable gloves and plastic apron for all contact with used laundry.
- All faecally contaminated linen and clothing should be handled with care using minimum handling in order to avoid dispersal of spores.
- At no time should contaminated linen be placed on the floor/surface or handled close to the body.
• Contaminated linen should not be allowed to accumulate.
• At no time should contaminated personal clothing be washed/sluiced by hand.

In a service users own home:
• all faecally contaminated bedding and clothing must be washed separately from other used linen and clothing. The articles should be washed as soon as possible at the highest temperature recommended by the manufacturer.

In a health and social care setting:
• all used laundry should be placed in a water soluble alginate bag and laundered as soon as possible
• the alginate bag should then be taken outside the room and immediately placed in a designated infected laundry bag prior to transportation to the laundry
• it is important to observe adequate thermal disinfection (65°C or above) wash temperatures for used items. Fabrics that will not withstand such high temperature should be washed at the highest temperature recommended by the items manufacturer.

11. Transfer and movement of service users

Please refer to Inter-Health and Social Care Infection Control Transfer Guidance for more detailed information.

• Symptomatic service users should not be transferred within or to another health and/or social care environment until they have had no diarrhoea for 48 hours and passed a formed stool (Bristol Form Scale type 1-4 - see Appendix 1) unless essential investigations or treatment is required.
• The ambulance/transport service and receiving area must be notified of the service user’s CDI status in advance.
• Staff preparing to transfer a service must complete an Inter-Health and Social Care Infection Control Transfer Form (see Appendix 6), stating the nature of the infection, symptoms and treatment. This form must accompany the service user and a copy kept for your records.

12. Death of a service user with Clostridium difficile infection

No special precautions other than those for a living service user are required for deceased service users.
13. Enhanced service user monitoring

In the event of a service user being suspected or confirmed with CDI the GP must be notified.

The following measures should also be implemented:

- instigation of enhanced monitoring of other service users for symptoms of CDI with close observation of all service users receiving antibiotic therapy
- other service users who develop diarrhoeal stools (type 5-7 Bristol Form Scale - see Appendix 1) should be isolated immediately and have a stool sample sent for C. difficile toxin testing. Fluid balance and a stool chart should be commenced
- staff wearing their own clothes for work should make sure that clothing is clean and washed at highest temperature recommended by the manufacturer.

14. Information for service users

Some areas now issue service users who are confirmed CDI or C. difficile colonised with a 'C. diff card'. The card is provided so the service user can present it at any consultation with a healthcare professional or admission to hospital. This will alert the healthcare worker/admitting unit to the service user's diagnosis of C. difficile and help to ensure if antibiotics are needed that only appropriate ones are prescribed.

15. References

Department of Health (2012) Updated Guidance on the Diagnosis and reporting of Clostridium Difficile


Department of Health (January 2009) Clostridium difficile infection: How to deal with the problem


Department of Health and Health Protection Agency (2013) *Prevention and control of infection in care homes – an information resource*

Health and Social Care Commission (October 2007) *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS*

Health and Social Care Commission (July 2006) *Investigation into outbreaks of Clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust*

Public Health England (May 2013) *Updated guidance on the management and treatment of Clostridium difficile infection*

16. Appendices

Appendix 1: The Bristol Stool Form Scale
Appendix 2: Medicines that can produce diarrhoea
Appendix 3: Daily Assessment of C. difficile infection record
Appendix 4: Stool Chart a C. difficile positive service user
Appendix 5: Care Pathway for service users with *Clostridium difficile*
Appendix 6: Inter-Health and Social Care Infection Control Transfer Form
### Appendix 1: Bristol Stool Form Scale

Please refer to this chart when completing a bowel history on the Inter-Health and Social Care Infection Control Transfer Form.

**Definition of diarrhoea**: An increased number (two or more) of watery or liquefied stools, i.e., types 5, 6 and 7 only, within a duration of 24 hours. Please remember: hands must be washed with liquid soap and warm water when caring for service users with diarrhoea.

NB Hands must be decontaminated after glove use.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces ENTIRELY LIQUID</td>
</tr>
</tbody>
</table>

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March 2015
North Yorkshire and York Community Infection Prevention and Control
Harrogate and District NHS Foundation Trust
Appendix 3: Medicines that can produce diarrhoea

Diarrhoea is a common adverse drug reaction (ADR) with many medicines. Antimicrobials account for about 25% of drug-induced diarrhoea though most cases are benign (Lee, 2006).

While diarrhoea has been seen with most medicines, the ones that are most commonly implicated are:

- acarbose;
- antimicrobials;
- biguanides;
- bile salts;
- colchicine;
- cytotoxics;
- dipyridamole;
- gold preparations;
- iron preparations;
- laxatives;
- leflunomide;
- magnesium preparations, eg antacids;
- metoclopramide;
- misoprostol;
- non-steroidal anti-inflammatory drugs (NSAIDS), e.g. aspirin, ibuprofen;
- olsalazine;
- orlistat;
- proton pump inhibitors; and
- ticlopidine.

Alternative diagnoses for the diarrhoea are important; therefore, careful attention should be paid to the temporal relationship between the time that the medicine is first taken and when the diarrhoea first appears.

Further information on adverse effects is available from local medicines information centres or by using the ‘search by section’ facility at http://emc.medicines.org.uk/
## Appendix 3: Daily assessment of C. difficile infection record

### Daily assessment of the severity of C. difficile infection

<table>
<thead>
<tr>
<th>Day</th>
<th>CDI Severity Score</th>
<th>Actions</th>
<th>Date, Time and Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>14</td>
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</tr>
</tbody>
</table>

Daily assessment can cease when service user is 48 hours clear of symptoms and passing Bristol Stool 1-4.

### Severity of C. difficile infection

1. **Mild disease**: typically ≤3 stools per day type 5-7 (on Bristol Stool Form Scale) and a normal white cell count (WCC).
2. **Moderate disease**: typically 3-5 stools per day type 5-7 and raised WCC (but <15x10⁹/L).
3. **Severe disease**: WCC >15x10⁹/L, or a temperature of >38.5°C or acutely rising serum creatinine (e.g., >50% increase above baseline) or evidence of severe colitis (abdominal symptoms or radiological signs). Note the number of stools may be less reliable as an indicator of severity.
4. **Life threatening disease**: includes hypotension, partial or complete ileus or toxic megacolon.
**Appendix 4: Stool chart for C. difficile positive service user**

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>CONSISTENCY</th>
<th>COLOUR</th>
<th>BLOOD/PUS /MUCUS</th>
<th>AMOUNT/ VOLUME</th>
<th>ABDOMINAL SYMPTOMS</th>
<th>DATE SAMPLE SENT</th>
<th>SIGNATURE AND PRINT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bristol Stool Chart Scale Type 1-7 (see Appendix 1)</td>
<td>State fresh/ bright red altered/ melaena</td>
<td>A - Small B - Moderate C - Large (Measure if appropriate)</td>
<td>i.e., bloating, cramps, pain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Care Pathway for service users with *Clostridium difficile*

This Care Pathway should be used in a care setting by healthcare workers caring for service users with *Clostridium difficile* (C. difficile) who are symptomatic and diarrhoea.

It should be used in association with your C. difficile Guidance and followed until the service user is symptom free for 48 hours and has passed a formed stool (a negative stool specimen is not required).

<table>
<thead>
<tr>
<th>Name of service user:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim: To safely care for a server with C. difficile reducing the risk of complications of the illness and preventing the spread of C. difficile to other service users.</td>
<td></td>
</tr>
</tbody>
</table>

1. The service user requires isolation nursing in their room. The room should preferably have en-suite facilities, or if not, an allocated commode which will stay in their room. The door to the service user’s room should, where possible, be kept closed.

2. Equipment required for isolation nursing, e.g., disposable apron and gloves, should be available inside and immediately outside the room.

3. A factsheet on C. difficile should be given to the service user and relatives as appropriate. A C. difficile card and leaflet may be sent to the service user by the local Community Infection Prevention and Control team.

4. Aperients should be omitted and an accurate record of bowel function using the Bristol Stool Form Scale should be maintained.

5. To prevent dehydration, fluid intake should be encouraged and recorded if indicated. The GP should be contacted if there are any concerns as subcutaneous or intravenous fluid support may be required.

6. A daily review by the GP of the service user’s condition should be made whilst they are symptomatic and documented. As directed by the GP, observations of temperature, pulse, respirations and blood pressure should be undertaken and recorded. Urgent medical advice should be sought if the service user’s condition deteriorates.

7. Administer antibiotic treatment for C. difficile if prescribed, e.g., metronidazole 400 mgs for 10-14 days. (Antibiotic treatment is available in the form of syrup if the service user has difficulty taking tablets.)

8. Disposable apron and gloves should be worn by all staff when entering the room, whether providing hands-on care or not.
   - A new disposable apron and gloves should be worn for each new task undertaken.
   - Aprons and gloves should be removed and hands washed with liquid soap, warm water and dried with paper towels immediately before leaving the service user’s room.
9. **Alcohol handrub must not be used as it does not kill C. difficile spores.**

10. All staff should wash their hands thoroughly using the correct technique.
    - Hands should be washed with liquid soap and warm running water and dried with paper towels.
    - Hands should be washed after each episode of care/intervention and before leaving the service user’s room.
    - After leaving the service user’s room, hands should be immediately washed again.

11. Assistance with hand hygiene should be given to the service user after using the commode or toilet and always before meals and drinks. If the service user is unable to wash their hands, moist skin cleansing wipes should be used.

12. The service user’s room and en-suite should be kept tidy and free from clutter to enable effective cleaning.

13. The room should be cleaned and then disinfected with a sporcidal product, e.g., Milton, at least once daily to reduce C. difficile bacteria from the environment. Milton should be used at a dilution of 1:20 (50 mls Milton in 1 litre of water) and a fresh solution should be made daily. All hard surfaces should be wiped with the solution, especially surfaces touched by the service user. Single use disposable cleaning cloths should be used. A designated colour coded bucket (yellow) should be used and disinfected with Milton after use.

14. Medical equipment should be single patient use or kept in the room. Items must be cleaned then disinfected and decontaminated thoroughly, e.g., with Milton at a dilution of 1:20 (50 mls Milton in 1 litre of water), before being taken out of the room.

15. **All surfaces of the commode or toilet should be cleaned (including frame, seat, under seat, lid, arms, flush handle) then disinfected with Milton at a dilution of 1:20 (50 mls Milton in 1 litre of water) after each use. Used commodes/slipper pans should be covered with a lid or paper towel during transportation to the sluice/dirty utility room.**

16. All used and soiled linen including clothing should be washed as ‘infected laundry’ and placed in a water soluble (alginate) bag inside the corrected coloured laundry bag, this should be removed immediately from the service user’s room to the laundry. Disposable apron and gloves should always be worn when handling used and/or soiled linen and clothing.

17. Waste should be placed in a foot operated bin with a lid and disposed of as infectious/clinical waste as directed by the waste contractor.

18. Visitors should be asked to wash their hands before leaving the room. Disposable apron and gloves are not required to be worn by visitors unless they are providing ‘hands on care’.

19. If the resident requires transfer to another healthcare facility, e.g., acute hospital, staff at the destination must be notified of the infection before transfer and documentation provided, e.g., Inter-health and Social Care Infection Control Transfer Form (see Appendix 6).

20. Isolation of the service user may be discontinued when they have had no diarrhoea for 48 hours and have passed a formed stool, Bristol Stool Chart 1-4 (see Appendix 1). There is no need to submit further faeces samples for clearance.

21. Once isolation is discontinued, the room must be deep cleaned, including furniture, carpet, curtains, soft furnishings. It is very important to deep clean the room to prevent the service user re-infecting themselves.

22. If symptoms re-occur, the service user should be isolated and a stool sample obtained if over 28 days since the last sample was tested.
Appendix 6: Inter-Health and Social Care Infection Control Transfer Form

Inter-Health and Social Care Infection Control Transfer Form

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health 2010)

“A registered provider must ensure that it provides suitable and sufficient information on a service user’s infection status whenever it arranges for that person to be moved from the care of one organisation to another, or from a service user’s home, so that any risks to the service user and others from infection may be minimised. If appropriate, providers of a service user’s transport should be informed of any infection.”

HOW TO USE THIS FORM

- Complete the form for every service user transfer to another health and social care provider.
- Please refer to the ‘Inter-Health and Social Care Transfer Guidance’ for full guidance on transfers and discharges at www.infectionpreventionandcontrol.co.uk.
- Complete the form prior to booking ambulance or other transport.
- A ‘confirmed risk’ service user is one who has been confirmed as being colonised or infected with organisms such as MRSA, glycopeptides-resistant enterococci, pulmonary tuberculosis and enteric infections including Clostridium difficile.
- Service users with ‘suspected risks’ include those who are awaiting laboratory tests to identify infectious organisms or who have been in recent contact with infected service users, e.g., in close proximity to an infected service user.
- Service users with ‘no known risks’ do not meet either of the two criteria above.
- For service users with diarrhoeal illness, please use the Bristol Stool Form Scale to indicate the frequency and type of stools over the past week. Please indicate in the ‘confirmed’ or ‘suspected’ risk box if the diarrhoea is known or suspected to be infectious.
- Please use the ‘Other information’ box to list personal protective equipment being used to assist in service user care. This equipment may include gloves, aprons or masks.
- Please print your name and contact details in the box provided.
- This form should accompany the service user during transfer and be given to the receiving facility. A copy should also be retained for evidence purposes and filed in the notes.

Service user details (insert label if available)
Name:
Address:
NHS number:
Date of birth:

Consultant:
GP:
Current patient location:

Transferring facility: (e.g. hospital – ward / care home)
Contact No:
Date of Transfer:
Have ICT been informed of the transfer of those service users with a confirmed/suspected risk: Yes [ ] No [ ] N/A [ ]

Receiving facility: (e.g. hospital – ward / care home / district nurse)
Contact no:
Have the following been informed of the transfer of those service users with a confirmed/suspected risk:
- Receiving ICT: Yes [ ] No [ ] N/A [ ]
- Transport provider: Yes [ ] No [ ] N/A [ ]

(*ICT = Infection Control team or Community Infection Prevention and Control team)

Is the service user an infection risk?
Please tick most appropriate box and give confirmed or suspected organism

- Confirmed risk
Organism:
- Confirmed risk
Organism:
- Suspected risk
Organism:
- No known risk

Service user exposed to others with infection:
(e.g., D&V) Yes [ ] No [ ]

If service user has diarrhoeal illness, please indicate bowel history for last week:
(based on Bristol Stool Form Scale)
Is diarrhoea thought to be of an infectious nature? Yes [ ] No [ ]

Relevant specimen results – MRSA (including admission screens), multi-resistant gram negative bacteria (e.g., ESBL), Clostridium difficile:
Specimen:
Date:
Result:

Treatment information including antimicrobial therapy:

Other information:

Is the service user aware of their diagnosis/risk of infection? Yes [ ] No [ ]

Does the service user require isolation? Yes [ ] No [ ]

If the service user requires isolation, please phone the receiving unit in advance.

Form completed by: [ ] Contact No: Date:

For further advice, please contact your local Community Infection Prevention and Control or Public Health England Team
North Yorkshire and York Community Infection Prevention and Control January 2015